HealthSelect

Maricopa Integrated Health System

Member Handbook and Certificate

Contract Year 2000

Revised 09/29/99

HealthSelect

Maricopa Integrated Health System

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Welcome To HealthSelect !

Thank you for choosing HealthSelect as your health plan. This HealthSelect Member Handbook/Certificate is designed to answer your questions regarding our Year 2000 services, benefits and procedures. Please keep it in a safe and convenient place for quick reference.

Introduction

HealthSelect is a health plan that is operated by the Maricopa Integrated Health System (MIHS), a division within Maricopa County Government. It is specifically designed for Maricopa County employees only. HealthSelect now offers a richly enhanced network of hospitals, pharmacies and physicians.

Maricopa Integrated Health System is HealthSelect's provider network which includes 12 Family Health Centers, an expanded network of private physician offices and nine hospitals throughout Maricopa County. See HealthSelect Provider Directory for a complete listing of contracted providers that has grown from 100 Primary Care Physicians (PCPs) in 1999 to over 240 PCPs in Year 2000.

All care received by HealthSelect members must be provided by HealthSelect-approved physicians, hospitals, pharmacies and ancillary providers. This rule is waived only in the case of an emergency when members may receive emergency care from any appropriate provider anywhere in the world.

HealthSelect Certificate

We would like to be responsive to you, our customer, by providing high quality care through HealthSelect. You can help us achieve this by learning to become an effective utilizer of health care services. The HealthSelect Member Handbook/Certificate outlines information you need to know in order to get the most from your health plan. Please keep it in a safe and convenient place for quick reference.

The HealthSelect benefit year begins January 1, 2000 and ends December 31, 2000. All benefits and services discussed in this booklet are applicable to this contract/benefit period only.

Definitions

Acupuncture	A therapy developed in East Asia using needles, heat and electrical stimulation to direct body energy. Acupuncture is used worldwide as a medical treatment for influencing nerve, muscle and organ activity.
Approved Provider	The HealthSelect physician, institution, hospital, ancillary professional or vendor that fulfills conditions of participation for delivery of care and services to health plan members.
Authorization	(Also referred to as "prior authorization"); an administrative process whereby MMCS prospectively reviews requested services to determine medical necessity and appropriateness.
Contract	The **HealthSelect Member Handbook/Certificate** and other documents provided to the member during the period of membership.
Contract Year	The calendar year from January 1st through December 31st. The contract year begins on the effective date of member enrollment and ends on December 31st.

Copayment

The amount a member pays directly to the participating health care provider at the time covered services are provided. Copayments are usually collected prior to receiving services.

Dependent(s)

Persons in a Subscriber's immediate family, i.e. spouse and natural and adopted children, eligible for HealthSelect coverage as determined by the employer. Children are considered dependents only through the age of 18 years. If your unmarried child is a full-time student at a college, university, technical school or other institute of learning, he or she can continue coverage through the age of 25. You may be asked for proof of continued registration of a full-time student. Failure to provide proof will result in dependent's disenrollment in HealthSelect.

Emergency

The sudden onset of a medical condition such that the absence of immediate medical attention could be expected to result in:

1. Loss of life
2. Serious impairment of bodily function; or
3. Loss or serious dysfunction of any bodily organ or part or otherwise
4. Placing the member's health in serious jeopardy.

Formulary

The HealthSelect-approved list of covered prescription medications available to HealthSelect members. HealthSelect requires use of generic prescription medications when available and when not contraindicated by the patient's medical condition.

Full-Time Student

An unmarried dependent, up to but not more than 25 years of age, who attends an accredited college, university, technical school or other institution of higher learning following graduation from high school and meets full-time requirements of that institution.

HealthSelect

A managed care health plan administered by MMCS to provide coverage for Maricopa County eligible employees and dependents.

Homeopathy

A system of medicine that strives to treat disease by stimulating the body's own defense and repair systems with highly diluted doses of medication.

Homeopathic Medicines

Homeopathic medicines are drug products made by homeopathic pharmacies in accordance with the processes described in the Homeopathic Pharmacopoeia of the United States, the official manufacturing manual recognized by the FDA.

Maricopa Managed Care Systems (MMCS)

A managed care organization owned by Maricopa County (Arizona) government which operates four health plans including HealthSelect.

Maricopa Integrated Health System (MIHS)

An agency within Maricopa County government that operates an integrated health care delivery system consisting of the Maricopa Medical Center, 12 Family Health Centers and a managed care organization, Maricopa Managed Care Systems (MMCS).

Medically Necessary and Medical Necessity	All health care and services received by HealthSelect members must be medically necessary and conform to the following criteria of medical necessity: Arizona Administrative Code R9-22-101 (69) defines medically necessary as "those covered services provided by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law to: Prevent disease, disability and other adverse health conditions or their progression, or To prolong life." Medical necessity is also established if: The disease or condition considered for treatment is one in which the safety and effectiveness of the proposed therapy has been demonstrated and documented, The stage of disease or condition is such that therapy can affect the outcome in a positive manner and/or The recipient of care has no other conditions which substantially reduce the potential for successful recovery.
Member	A Maricopa County employee or dependent who is enrolled in HealthSelect and is eligible for covered benefits.
Osteopathic Manipulation/ Craniosacral Therapy	The subtle movement/manipulation of body parts, including muscle, bone and connective tissue, to re-establish a healthy balance between organ systems and the nervous system.
The Plan	Refers to HealthSelect, the managed care health plan for Maricopa County employees, as previously defined in this HealthSelect Certificate.
Primary Care Physician (PCP)	A physician, such as family practice, internal medicine, or pediatrician, who is responsible for the overall management of a member's health care. During pregnancy, the member's obstetrician assumes the role of a PCP for the term of the pregnancy and postpartum care.
Provider Network	Physician, hospitals, ancillary providers and other health care vendors approved by or contracted with HealthSelect to provide care and service to its members. HealthSelect delivers services through its major provider network: Maricopa Integrated Health System (MIHS) which includes Maricopa Medical Center (MMC), 12 Family Health centers, the Comprehensive Healthcare Center (CHC) at MMC and an expanded network of other hospitals and private physicians.
Subscriber	The employee who enrolls in HealthSelect under this agreement.
Urgent	A condition requiring medical attention within a few hours; a condition which is not immediately life threatening or severe, but for which delay of service, until the member can be treated by his/her primary care physician, would be detrimental.

Member Rights and Responsibilities

Member Rights

You Have the Right To

- Receive the services and benefits outlined in the HealthSelect Member Handbook/Certificate.
- Choose a primary care physician from the provider network.
- Be treated with respect and dignity.
- Expect confidentiality of all information, including medical records, unless required by law. You may look at your medical records as allowed by federal and state laws.
- Privacy during treatment.
- Know the name and credentials of professionals providing treatment, information about diagnoses, treatment options and expected results.
- Participate in decisions about the kind of care you receive.
- Refuse any treatment and to be informed of the consequences of **not having** the treatment.
- Register complaints and have them heard and resolved.

Member Responsibilities

It Is Your Responsibility To

- Present your membership identification card when receiving care/treatment.
- Pay the applicable copayment at the time care/treatment is given.
- Arrive at your appointment on time. Please cancel 24 hours in advance if you cannot keep your appointment.
- Utilize the authorized provider network except in emergency life-threatening situations.
- Schedule appointments with your primary care physician rather than using Emergency/Urgent Care facilities for non-emergent/non-urgent illnesses.
- Give true and complete facts about your health and inform your physician of any unexpected changes in your condition and follow prescribed treatment regimen.
- Treat providers and their staff with dignity and respect.

Membership Cards

HealthSelect provides members with an identification card that includes their name, date of birth, ID number and gender.

You should carry your member ID card with you at all times. Your HealthSelect member ID card is required for all health care services, especially urgent care and emergency room services.

Permitting someone else to use your membership card to obtain services is prohibited and will result in termination of your coverage. If your card is lost or stolen, please call Member Services at (602) 344-8760 or 1-800-582-8686.

Choosing Your Primary Care Physician

Most medical services are provided and/or coordinated by your Primary Care Provider (PCP), including referrals to specialists when needed.

If you wish to change your PCP, please contact Member Services at (602) 344-8760. The PCP change will become effective the first day of the following month. You will be allowed to change PCPs no more than four times per contract year.

Refer to the enclosed Provider Network Directory to choose your PCP.

How to Access Services

You do not need a PCP referral to visit the following specialists:

- Dentists
- Pediatricians
- Family practitioners
- Internists
- Obstetricians/gynecologists (OB/GYN)

Please contract your PCP or HealthSelect Plan for information on how to access specific medical services.

It is necessary to make an appointment each time you see your PCP, specialist or dentist. You should also call to cancel if you will not be able to make your appointment.

How To Set Up a Physician's Appointment

1. Have your HealthSelect ID card with you when you call for an appointment. You will need to give the ID number on the card.
2. Tell the receptionist/clerk your
   - Name
   - ID Number from your card
   - Primary Care Physician's name
   - Reason for requesting an appointment (if urgent "same day" treatment is required, let the receptionist/clerk know; you may be transferred to a triage nurse)
3. On the day of your appointment
   - Be on time
   - Show your ID card
   - Pay applicable copayments
4. **Be sure to call and cancel your appointment one day in advance if you cannot keep it.** This will assure someone else the opportunity to have an appointment.

Specialist Physician's Appointments

You do not need a PCP referral or prior authorization from HealthSelect in order to access the following specialists:

- Pediatricians
- Family practitioners
- Internists
- OB/GYNs

For most other contracted specialists you do not need HealthSelect prior authorization. However, **you will need a referral from your PCP.** You may not use a non-contracted specialist without prior authorization from HealthSelect.

If you need to cancel an appointment with a specialist, please notify your PCP, as well as the specialist.

Hospitalization

Should the need arise for you to be hospitalized, your PCP will make all the necessary arrangements. All scheduled admissions must be prior authorized. In the event of an emergency, go to the nearest hospital. The hospital will be expected to notify HealthSelect within 48 hours of receiving treatment. See "A Guide to Appropriate Use of a Hospital Emergency Room" on the next page.

Urgent Care Services

Urgent care means requiring medical attention within a few hours for a condition that is not immediately life-threatening or severe, but for which delay of service would be detrimental.

To Obtain Urgent Care Services

Family Health Centers (FHCs):
Call your PCP during business hours. After hours or holidays, Family Health Centers have an answering service to assist you. If you are unable to reach assistance, call the 24-Hour Authorization Unit, (602) 344-8811 or 1-800-552-8808 to be directed to an urgent care clinic.

Show Your ID Card.
If you go to the Urgent Care Center before calling the Prior Authorization Unit, ask the Urgent Care Center to call (602) 344-8111 or 1-800-552-8808 to get approval before receiving care.

Private Physician's Offices:
Call your PCP for instructions. After hours, call the 24-Hour Authorization Unit at (602) 344-8111 to be directed to an urgent care clinic.

Emergency Services

An emergency is defined as a serious accident or sudden illness that, if not treated immediately, could result in loss of life, limb or body function.

In an emergency, go directly to the nearest hospital or dial 911. You do not need prior authorization from HealthSelect to seek emergency care services. However, if you are admitted to the hospital, you should inform the hospital to call the 24-hour authorization number within 48 hours for prior authorization.

If you go to an emergency room, you will be required to pay a $50.00 copayment. If you are admitted, the $50 copayment will be waived.

A Guide to Appropriate Use of a Hospital Emergency Room

Good Reasons to Go:

- Chest pain
- Trouble breathing or stopped breathing
- Deep cuts or bleeding that you cannot stop
- Drug overdose or poisoning, or a suicide attempt
- Seizures that are not usual for you
- A major car accident
- When you think you have a broken bone
- Gunshot or stab wound
- If you are pregnant and have severe pain or bleeding with passage of clots
- Serious electric shock or lightning injury
- Stroke symptoms: numbness or paralysis of an arm or leg, suddenly slurred speech, lack of responsiveness, severe headache
- Possible broken neck or back
- Choking which you cannot stop
- When a child older than 2 months has a fever of 101 degrees or higher
- When a child younger than 2 months has a fever of 103 or higher

Do NOT go to the Emergency Room for:

- Routine health care
- Toothache
- Earaches
- Minor persistent headaches
- Body aches, colds, coughing, sore throat and flu
- Hay fever and sinus problems
- Diaper rash
- Chronic back pain or lumbago
- Broken cast
- Teething
- Removal of stitches
- Sunburns or minor cooking burns
- Minor injuries

A hospital emergency room should only be used for true emergencies. If you are not having a true emergency, call your PCP or his/her triage nurse first to discuss your condition and obtain advice. HealthSelect will not be responsible for any charges resulting from non-emergent use of the emergency room. This will be determined by HealthSelect.

Your emergency room copayment ($50) is due at the time services are rendered. If you are admitted to the hospital as a result of your emergency room visit, the $50 copayment will be waived.

Out-of-Area Emergency Services

If you are traveling outside of Maricopa County and experience an urgent health problem, it is permissible to use a local physician, urgent care services when appropriate or a hospital emergency room in an emergency situation. Upon arrival in the facility, show the staff your HealthSelect membership card. The message on the reverse side tells the health care providers how to obtain eligibility, authorization and benefit information about you. Failure to properly notify HealthSelect within 48 hours of treatment may result in denial of payment to the provider for these services. HealthSelect will determine if the services are considered urgent or emergent. If you are pregnant and travel outside of Maricopa County within 30 days of your due date, your delivery at a non-network hospital may not be covered.

Out-of-area providers may ask you to pay your health care bill after receiving services. If approved by Health Select, you will be reimbursed for all costs associated with an emergent/urgent care episode of treatment by presenting a copy of your receipt and any other paperwork the provider had given you as proof of urgent care that has been rendered.

Send the original receipt and paperwork, plus your current address and phone number (home and work) to HealthSelect at:

HealthSelect
Attention: Member Services
2502 E. University, Suite 125
Phoenix, AZ 85034

Once approved, it takes approximately 6-8 weeks to process your reimbursement check. Call Member Services at (602) 344-8760 at the end of the 8 weeks to check processing status if you do not hear from us. If your request for reimbursement is denied, you will receive a formal notification with an explanation of the denial reason.

Please remember that routine, non-emergency and non-urgent care are not covered services from HealthSelect when you are out of HealthSelect's service area (outside Maricopa County). HealthSelect will not reimburse the member for such costs.

Member Copayments

HealthSelect members are responsible for making copayments at the time service is received. It is not accepted practice for providers to bill members for copayments. HealthSelect members should be prepared to make the copayment when they arrive at the service site. Please see the Standard Benefits Summary and Dental Benefits Summary of this Member Handbook/Certificate.

Prescription Coverage

A member may purchase covered prescriptions from a participating pharmacy when ordered by a HealthSelect physician. HealthSelect uses a formulary or a list of covered medications. If your primary care provider or a specialist physician wants to prescribe a medication that is not included on the formulary, they must contact your HealthSelect Plan for prior authorization to prescribe the drug. Non-formulary drugs will only be approved if there is documented medical evidence that the existing formulary drug is not adequate. Only HealthSelect-approved physicians and dentists can write prescriptions for medications in the formulary. All others will be rejected and not authorized by the approved pharmacy's computer system. This means the member will have to pay for the prescription and will not be reimbursed by HealthSelect. Written prescriptions can only be filled at CHC and FHC pharmacies or contracted community pharmacies. See the HealthSelect Provider Directory for the list of approved pharmacies before you fill your prescriptions.

Members must pay a $5.00 copayment for each prescription or refill. The copayment is due at the time the prescription is received/delivered. The pharmacy has the right to withhold the prescription if the member does not make the required copayment. Each prescription or refill will be limited to no more than a thirty(30) day supply, unless HealthSelect determines that a longer period is warranted.

If you fill your prescription at a pharmacy that is located in a Family Health Center (FHC), you may have it delivered to your home. This is a service that is available only to members.

In an emergency situation, out-of-area pharmacies may require the member to pay for a prescription written by an out-of-area emergency room physician. In such cases, the member should obtain a receipt which can then be submitted to HealthSelect for reimbursement. The member will be reimbursed for the actual costs of the prescriptions. Make a copy of the receipt for your records and send the original with a cover letter explaining the circumstances to:

HealthSelect
Attn. Member Services
2502 E. University, Suite 125
Phoenix, AZ 85034

It will take 6-8 weeks to process a reimbursement check. HealthSelect reserves the right to determine the emergent nature of the care before reimbursing the member for prescription expenses. If your request for reimbursement is denied, you will receive a formal notification with an explanation of the reason for the denial.

Covered Benefits

Covered benefits are listed in the HealthSelect *Supplemental Benefits* and *Standard Benefits Summary* sections of this certificate.

Coordination of Benefits

If you or your dependents are entitled to benefits under another group health insurance, HealthSelect will follow the customary coordination of benefits process, which entails billing other health insurance companies for applicable benefits.

Denial of Covered Benefits

HealthSelect will not approve or authorize payment in the following situations:

A. The service is not a covered benefit under HealthSelect. Refer to the HealthSelect Standard Benefits Summary Section for covered benefit descriptions and a listing of all health plan limitations and exclusions.

B. The service is not medically necessary. Refer to the Definitions Section in this booklet.

C. The service is provided by a health care professional, institution or other vendor who is not approved by or contracted with HealthSelect and the care or service was not related to an emergency.

D. The service is for routine medical care but was provided in an emergency room or Urgent Care Center (UCC). Emergency Room (ER) services are for emergencies only and (UCC) are for urgent problems only. No other kind or type of care is covered in an Emergency Room or Urgent Care Center.

Complaint, Grievance and Appeals Process

If you have a question or concern about services received, call the Member Services Department at (602) 344-8760. If your question or concern has not been answered to your satisfaction, call your Personal HealthSelect Specialist at (602) 344-8425 for personal attention. If you continue to be dissatisfied about care or services received, (including personnel, facilities, waiting times, claim or treatment denials, etc), you may request for the matter to be handled as a grievance. All grievances must be in writing and sent to:

HealthSelect
Attn: Grievance Coordinator
2502 East University, Suite 125
Phoenix, AZ 85034
Phone (602) 344-8425
Fax (602) 344-8515

The Grievance Coordinator will acknowledge receipt within 5 days. Grievances must be filed no later than 60 days after the date of action, decision, or incident to which they pertain. The Grievance Coordinator will review all circumstances surrounding the issue and respond to the member in writing within 30 days with the proposed resolution.

Should the member not agree with the Grievance Coordinator's determination, a written appeal can be submitted within 30 days from the mailing date of the grievance decision to:

Maricopa Managed Care Systems
HealthSelect Grievance Unit
2502 East University, Suite 125
Phoenix, AZ 85034
Fax (602) 344-8515

The appeal is sent to the Grievance Committee within HealthSelect for a determination. The Grievance Committee will:

- Review all the records and written material related to the case.
- Interview the member registering the grievance (if appropriate).
- Make the final grievance decision after which the member will be notified in writing of the decision.
- Participate in the decision to grant an extension. If, on the 45th day following the filing of the grievance, it appears additional time is required to review the case, a letter will be sent to the grievant requesting a 30-day extension. All parties must agree to the extension or the final decision will be made within the 60-day time limit.

It is a condition of participation in HealthSelect that the member agrees to initiate and complete the complaint, grievance and appeals process before initiating any arbitration against HealthSelect. The costs of initiating arbitration proceedings shall be paid for by the member. HealthSelect agrees to arbitrate all such matters or disputes arising under this HealthSelect Certificate or based upon contract theory.

Termination by Cause

HealthSelect membership will be terminated when a subscriber or member:

A. Fraudulently uses HealthSelect services or knowingly permits fraudulent use of HealthSelect services by another person.

B. Refuses to pay required copayments.

C. Behaves in a manner that disrupts and/or prevents a health care provider from servicing the subscriber, member and/or other patients in a safe manner. Violent outbursts, verbal and/or physical threats of violence and/or possession of a weapon within the health care setting are examples of some, but not all situations that will result in immediate termination of a HealthSelect member.

The subscriber and his or her dependents will be terminated from the health plan, not just the disruptive member, if any of the above situations occur. Termination of HealthSelect membership requires that your employer (Maricopa County) be notified of the reason for termination.

Termination of Employment

If you leave your employment, you and your dependents may be entitled to continued HealthSelect coverage under federal COBRA provisions. Refer to the HealthSelect Certificate for complete COBRA description. Please contact your employer (Maricopa County's Benefits Department) regarding COBRA and continuation of coverage requirements.

Notification of Change

You need to notify Maricopa County Benefits Department at (602) 372-2837 and HealthSelect.

- Change your name, address and/or phone number
- Add a dependent through marriage, birth or adoption
- Drop coverage for a dependent due to a divorce or for a dependent who exceeds dependent age limit

The HealthSelect Member Services Unit can be contacted at (602) 344-8760 or 1-800-582-8686, TDD (602) 344-8789, Monday through Friday, 8:00 a.m. to 5:00 p.m. except holidays.

Coverage Under HealthSelect

A. Your spouse and/or your natural and adopted unmarried children can be covered under HealthSelect. Children are considered dependents only through the age of 18 years or through the age of 25 years if a full-time student. Unmarried children are covered through the age of 18 years. If your unmarried child is a full-time student at a college, university, technical school or other institute of learning, he/she can continue his/her coverage through the age of 25 years. You must show proof of the child's continued registration as a full-time student. Handicapped children over the age of 18, primarily supported by you and not capable of self-sustaining employment, may remain a "dependent" with periodic proof of disability.

B. Pursuant to state law, dependents who live outside of Maricopa County (the HealthSelect service area), for whom you are responsible for insuring under a court order (legal separation, divorce or custody decree) can be covered under HealthSelect. However, all members may only use HealthSelect-contracted providers within HealthSelect's service area (Maricopa County). Therefore, members and covered dependents can only be covered when outside of Maricopa County in the event of a medical emergency. You must provide a copy of the written court decree to your employer (Employee Benefits Division) and to the HealthSelect Member Relations Unit (2502 East University Drive, Phoenix, AZ 85034).

C. **Subrogation/Right of Reimbursement.** As a condition to receiving benefits under this Plan, Covered Person(s) agree to transfer to the Plan their rights to recover damages to the extent of benefits paid by the Plan when an Injury or Illness occurs through the act or omission of another person. If a Covered Person(s) receives payment from another person or business entity on account of an Injury or Illness, Covered Person(s) agrees to reimburse the Plan to the full extent of benefits paid. If a repayment agreement is required to be signed, all rights of recovery are transferred to the Plan regardless of whether it is actually signed. It is only necessary that the Injury or Illness occur through the act or omission of another person. The Plan's rights of full recovery may be from a third party, any liability or other insurance covering the third party, the Covered Person(s)' own uninsured motorist insurance, under-insured motorist insurance, any medical payments, no-fault or school insurance coverages which are paid or payable. The Plan may enforce its reimbursement rights by requiring the Covered Person(s) to assert a claim to any of the foregoing coverages to which he/she may be entitled. Covered Person(s) shall provide all requested accident and insurance information to Plan representatives. The Plan shall not be required to pay any portion of Covered Person(s)' attorneys' fees or other costs associated with a lawsuit.

D. Recovery of Payments. The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. in error;
2. pursuant to a misstatement contained in a proof of loss; or
3. pursuant to a misstatement made to obtain coverage under this Plan within two (2) years after the date such coverage commences; or
4. with respect to an ineligible person; or
5. in anticipation of obtaining a recovery in subrogation if a Covered Person fails to comply with the provision of Paragraph C above; or
6. pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan holder to pay benefits under this Plan in any such instance.

Such deduction may be made against any claim for benefits under this Plan by a Covered Person if such payment is made with respect to such Covered Person.

COBRA Coverage

On April 7, 1986 a federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the new law. **(Both you and your spouse should take the time to read this notice carefully.)**

If you are an employee of Maricopa County covered by the county's medical, employee assistance program, dental or health care reimbursement account you have the right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by Maricopa County's group health plans you have the right to choose this continuation coverage; if you lose your group health coverage under the medical employee assistance program, dental or health care reimbursement account for any of the following four reasons:

1. The death of your spouse;
2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes entitled to Medicare.

In the case of a dependent child of an employee covered by Maricopa County's group health plans, he or she has the right to continuation coverage if group health coverage under the medical, employee assistance program, dental or health care reimbursement account for any of the following five reasons:

1. The death of a parent
2. A termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment;
3. A parent's divorce or legal separation;
4. A parent becomes entitled to Medicare.
5. The dependent child ceases to be a "dependent child" under the employers' group health plans.

Under the law, the employee or a family member has the responsibility to inform the plan administrator, Maricopa County Human Resources, within 60 days of the date of the event or the date in which coverage would end under the Plan because of the event, whichever is later. Maricopa County has the responsibility to notify the COBRA Administrator, Administrative Enterprises, Inc., of the employee's death, termination, reduction in hours of employment or Medicare entitlement. Similar rights may apply to certain retirees, spouses and dependent children if your employer commences a bankruptcy proceeding and these individuals lose coverage.

When the COBRA Administrator, Administrative Enterprises, Inc., is notified that one of these events has happened, the COBRA Administrator will in turn notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above, or the date notice of your election rights is sent to you whichever is later, to inform the COBRA Administrator, Administrative Enterprises, Inc., that you want continuation coverage.

If you do not choose continuation coverage, your group health insurance will end.

If you choose continuation of coverage, Maricopa County is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. The new law requires that you be afforded the opportunity to maintain continuation coverage for three years unless you lost group health coverage because of a termination of employment or a reduction in hours. In that case, the required continuation coverage period is 18 months. This 18 months may be extended to 36 months if other events (such as death, divorce, legal separation or Medicare entitlement) occur during that 18-month period.

The 18 months may be extended to 29 months if an individual is determined (under Title II or XVI of the Social Security Act) to have a disability and the COBRA Administrator, Administrative Enterprises, Inc., is notified of that determination within 60 days. The affected individual must also notify the COBRA Administrator, Administrative Enterprises, Inc., within 30 days of any final determination that the individual no longer has a disability. In no event, will continuation coverage, last beyond three years from the date of the event that originally made a qualifying beneficiary eligible to elect coverage.

However, the law also provides that your continuation coverage may be terminated for any of the following five reasons:

1. Employers no longer provides group health coverage to any of its employees;
2. The premium for your continuation coverage is not paid on time;
3. You become covered by another group plan, unless the plan contains any exclusions or limitations with respect to any pre-existing condition you or your covered dependents may have;
4. You become entitled to Medicare;
5. You extend coverage for up to 29 months due to your disability and there has been a final determination that you no longer have a disability.

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you may have to pay all or part of the premium for your continuation coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium. (The law also says that, at the end of the 18-month or three-year continuation coverage period, you must be allowed to enroll in an individual conversion health plan provided under Maricopa County's health plans, if the contract provides for a conversion option.).

This law applies to Maricopa County beginning on April 07, 1986. If you have any questions about the law, please contact:

Administrative Enterprises, Inc.
Maricopa County COBRA Program
3404 West Cheryl Drive, Suite 280
Phoenix, AZ 85051-9588
(602) 789-1170

HIPAA

On August 21, 1996, a new federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) [Public Law 104-191], was enacted. The HIPAA changed the continuation coverage requirements under COBRA that apply to the Maricopa County plans. Generally, effective January 1, 1997, (regardless of whether the qualifying event occurred before, on or after that date) under COBRA, if the qualifying event is a termination or reduction in hours of employment, affected qualified beneficiaries are entitled to continue coverage for up to 18 months after the qualifying event, subject to timely premium payments. Before HIPAA, this 18-month period could be extended for up to 11 months (for a total COBRA coverage period of up to 29 months from the initial qualifying event) if an individual was determined under the Social Security Act to have a disability at the time of the qualifying event and if the plan administrator was notified of that disability determination within 60 days of the determination and before the end of the original 18-month period.

Under the new law, if a qualified beneficiary is determined to have a disability under the Social Security Act at any time during the first 60 days of COBRA coverage, the 11-month extension is available to all individuals who are qualified beneficiaries due to the termination or reduction in hours of employment. The individual with a disability can be a covered employee or any other qualified beneficiary. However, to be eligible for the

11-month extension, affected individuals must still comply with the notice requirements in a timely fashion.

Furthermore, a child that is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the HealthSelect Plan and the requirements of Federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to Maricopa County Human Resources or AEI of the birth or adoption.

In addition to changing some of the COBRA requirements, HIPAA restricts the extent to which group health plans may impose pre-existing condition limitations. These rules are generally not effective until Plan Years beginning after June 30, 1997. HIPAA coordinates COBRA coverage with these new limits as follows:

Under COBRA, your right to continuation coverage terminates if you become covered by another employer's group health plan that does not limit or exclude coverage for your pre-existing conditions. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA continuation coverage cannot be terminated due to your new health plan coverage. However, if the other plan's pre-existing condition limitation rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the Maricopa County Cafeteria Plan may terminate your COBRA coverage.

If you have any questions about the COBRA law, please contact Maricopa County Human Resources, (Employee Benefits) 301 West Jefferson Street, Phoenix, AZ 85003, or its agent, Administrative Enterprises, Inc., Maricopa County COBRA Program, 3034 West Cheryl Drive, Suite 280, Phoenix, AZ 85051. Also, if you have changed marital status, or you or your spouse have changed address, please notify Maricopa County Human Resources at the above address, within 31 days.

Prior Authorization and In-Plan Network Changes

All care received by HealthSelect members must be provided by approved or contracted physicians, institutions, agencies and vendors. This rule is waived only in the case of an emergency. Members may receive emergency care from any appropriate provider anywhere in the world.

Please see *The Standard and Supplemental Benefits Summary* Chart for the specific services/care which require prior authorization from HealthSelect and those services which do not require prior authorization.

HealthSelect members who obtain routine, non-emergency care outside the approved provider network will be financially responsible for that care. Members may only use non-approved providers when in a medical emergency. In all other cases, you must obtain prior authorization. HealthSelect reserves the right to determine what constitutes medically necessary, emergency care according to descriptions included in this certificate. All care delivered in an emergency room will result in a $50 copayment. The $50 copayment will be waived if admitted to the hospital.

HealthSelect reserves the right to change the authorization status of health care services upon 30 days written notice to its subscribers.

Provider Network

HealthSelect now offers you a wider Provider Network than was available in previous years.

Members may call Member Services to choose a Primary Care Physician if not indicated on the enrollment form. Members within a family may choose different Primary Care Physicians. **Members may change PCPs by notifying the Member Services Unit (602) 344-8760 or 1-800-582-8686).** All PCP changes will become effective the first day of the following month from the member's date of request. HealthSelect will confirm the member's PCP change in writing to the subscriber. You may change, for no cause, no more than four times per contract year.

Member Copayments

HealthSelect members are responsible for making copayments at the time service is received. It is not accepted practice for providers to bill members for copayments. HealthSelect members should be prepared to make the copayment when they arrive at the service site. **Office visit copayments apply to any encounter, including an Urgent Care Center visit in which the member is cared for by a Physician, Nurse Practitioner, Physician Assistant, Dentist, Audiologist, Audiology Technician, Optometrist or Optometry Technician. HealthSelect requires copayments for the following services:**

Copayment Summary

SERVICE MODALITY	COPAYMENT
Primary Care Physician Office Visit	$5
Specialty Care Physician Office Visit	$5
Audiologist Office Visit	$5
Emergency Room Services	$50
If the member is admitted to the hospital directly from the Emergency Room, the $50.00 copayment is waived.	
Urgent Care Visit	$5
Dental Office Visits	$5
(plus 20% of service costs when applicable)	
Outpatient Therapy	$5
Outpatient Rehabilitation	$5
Prescription Medications	$5
Chiropractic Services	$10
Alternative Medicine	$10
Weight Management	$10
Lab Services, Mammograms, X-rays	$0
Colorectal Exam, Pap Smear Exam, Prostate Cancer Screening	$0
Adult Immunizations without PCP encounter	$0
Home Health Visits	$0

Refer to the following *Supplemental Benefits* and *Standard Benefits Summary* Chart for exact copay amounts.

Visits made solely for all routine immunizations, x-rays, or lab tests that are not associated with an encounter with a physician do not require a copayment (see *Standard Benefits Summary* Chart).

Supplemental Benefits Summary

SUPPLEMENTAL BENEFITS FOR 2000	COVERAGE STATUS	PRIOR AUTHOR. REQUIRED?	HOW TO ACCESS SERVICES
Chiropractic Care	Initial assessment plus six visits per year. Additional chiropractic services covered if medically necessary. $10 copayment per office visit. Limit of two x-rays per contract year. Member will be responsible for charges beyond covered benefit limitation.	No	Direct access. PCP referral **not** required. Visits beyond six will require PCP referral and HealthSelect prior authorization.
Alternative Medicine*	Initial assessment plus four visits per year. $35.00 credit for supplies prescribed by alternative medicine provider (*see notes on how to obtain credit). $10.00 copayment per office visit. Member will be responsible for charges beyond covered benefit limitation.	No	Direct access PCP referral **not** required.
Health Club Membership	Discounted membership and/or monthly fees. No copayment.	No	Direct access Call Member Services.

Supplemental Benefits Summary

SUPPLEMENTAL BENEFITS FOR 2000	COVERAGE STATUS	PRIOR AUTHOR. REQUIRED?	HOW TO ACCESS SERVICES
Adult Dental	Diagnostic and preventive treatment and some restorative services (see Table of Dental Benefits). $5 copayment per office visit. 20% service fee on some services. Member will be responsible for charges beyond covered benefit limitation.	No	Direct access PCP referral **not** required.
Weight Loss Counseling*	Initial assessment plus three visits. $10 copayment per office visit (see notes regarding vouchers). Member will be responsible for charges beyond covered weight loss benefit limitation. Additional counseling related to a medical condition is covered with PCP referral.	No	Direct access PCP referral **not** required. Call Member Services to obtain vouchers.

Note: Chiropractic Care, Alternative Medicine, Dental, Weight Loss/Nutrition Counseling Services are available from only HealthSelect-contracted Providers that are listed in the HS Provider Directory. Prescriptions ordered by providers must be in HealthSelect formulary.

Standard Benefits Summary

STANDARD BENEFITS FOR 2000	COVERAGE STATUS/COPAYMENT	PRIOR AUTHOR. REQUIRED?
Office/Clinic Visit Primary Care Physician/Nurse Practitioner/ Physician Assistant Services	$5 copayment per visit – COVERED.	No
Specialist Physician Services	$5 copayment per visit – COVERED.	No (except for infertility specialist, pain management specialist, podiatrist and allergist outside of FHC).
Well-Child Care, Children's Periodic Health Exams	$5 copayment per visit – COVERED.	No
Physician Visits to Hospital, Skilled Care Facility or Rehab Facility	$0 copayment – COVERED.	No
Hearing Exams	$5 copayment per visit – COVERED.	No
Hearing Aids	$120 allowance per contract year – COVERED, $5 copayment.	No
Vision Exams	(See Sight Care Copayment) Available through Sight Care.	No
Eye Glasses and Contact Lenses	(See Sight Care Copayment) Available through Sight Care.	No
Eye Wear Following Cataract Surgery	COVERED.	No

Standard Benefits Summary

STANDARD BENEFITS FOR 2000	COVERAGE STATUS/COPAYMENT	PRIOR AUTHOR. REQUIRED?
Routine Pediatric Immunizations, Adult Immunizations (Flu, Pneumovax and Hepatitis B for high risk)	None if obtaining immunization only. $5 copayment if combined with doctor visit – COVERED.	No
Immunizations for Foreign Travel	NOT COVERED.	N/A
Routine Injectables on Formulary	$5 copayment per visit – COVERED.	No
Pediatric Dental Services	See Pediatric Dental Benefits section; $5 copayment per office visit, $1200 annual cap. Some services require a 20% service charge in addition to the dental visit copayment – COVERED.	No
Adult Dental Services	See Adult Dental Benefits Section; $5 copayment per office visit. No dollar limit except for limit on scope of services. Some services require a 20% service charge in addition to $5 dental office visit copayment – COVERED.	No
Surgical Services: Inpatient or Outpatient and Anesthesia	$0 copayment – COVERED.	Yes
Laboratory and Radiology (X-ray) Services	$0 copayment – COVERED.	No (if in network) Yes (if out of network)
Rehabilitation Services Inpatient, Home Care	$0 copayment – COVERED.	Yes

Standard Benefits Summary

STANDARD BENEFITS FOR 2000	COVERAGE STATUS/COPAYMENT	PRIOR AUTHOR. REQUIRED?
Outpatient Rehabilitation Services	$5 copayment per office visit.	Yes
Physical Therapy, Speech Therapy, Occupational Therapy	COVERED up to 60 days; $5 copayment.	Yes
Psychiatric, Mental Health or Behavioral Health Services	NOT COVERED. (Covered by Maricopa County – please call the county's Behavioral Health Provider at 1-800-343-2183); drugs prescribed by the Behavioral Health Provider are covered but require prior authorization.	Not applicable
Medical Social Worker, Health Education Services	$0 copayment – COVERED.	No
Emergency Ambulance Transport*	$0 copayment – COVERED.	No
Non-Emergency Transport	NOT COVERED.	Not applicable
Durable Medical Equipment (DME)	$0 copayment – COVERED.	Yes
Prostheses and Orthotic Devices*	$0 copayment – COVERED. Limit $7,000 per year.	Yes
Medical Supplies (Home Health)	Covered, when medically necessary, $0 copayment.	Yes

Standard Benefits Summary

STANDARD BENEFITS FOR 2000	COVERAGE STATUS/COPAYMENT	PRIOR AUTHOR. REQUIRED?
Blood and Blood Products	$0 copayment – COVERED.	Yes
Nuclear Medicine	$0 copayment – COVERED.	No
Organ Transplants*	$0 copayment – COVERED if not experimental or investigational (must meet HealthSelect Plan criteria and be prior authorized).	Yes
Immunosuppressive Drugs*	$5 copayment per prescription (within formulary); must meet HealthSelect criteria and be prior authorized.	Yes
Chemotherapy	$0 copayment – COVERED.	Yes
Dialysis	$0 copayment – COVERED. (Only Staff Assist or out of network.)	Yes
Podiatry Services*	NOT COVERED for routine foot care; COVERED if medically necessary; $5 copayment per visit.	Yes
Home Health Agency Skilled Services*	COVERED through a Medicare-certified Home Health Agency – $0 copayment.	Yes
Hospice Services	$0 copayment – COVERED by a Medicare-certified Hospice.	Yes
Mammograms	$0 copayment – COVERED.	No (if within Network)

Standard Benefits Summary

STANDARD BENEFITS FOR 2000	COVERAGE STATUS/COPAYMENT	PRIOR AUTHOR. REQUIRED?
Prostate Cancer Screening	$0 copayment – COVERED.	No
Pelvic Exam and/or Pap Smears	$5 copayment per office visit; $0 copay for exam – COVERED; screening limit one per year.	No
Prenatal Care, Delivery	$5 per prenatal care visit – COVERED; hospitalization must be authorized separately; $0 copayment for delivery.	Yes (global authorization needed for physician)
Family Planning*	$5 copayment per office visit. No more than one Norplant implant or removal in five years – COVERED.	No
Allergy Testing and Treatment	$5 copayment per office visit – COVERED.	Yes (if outside HS network)
Second Medical Opinion	$5 copay; COVERED when medically appropriate.	Yes (must be approved by HealthSelect Medical Director)
Inpatient, Acute, Medical Hospital Care	$0 copayment – COVERED.	Yes
Outpatient Medical Hospital Services	$0 copayment – COVERED.	Yes
Skilled Care Facility Services	$0 copayment – COVERED up to 20 days per illness.	Yes

Standard Benefits Summary

STANDARD BENEFITS FOR 2000	COVERAGE STATUS/COPAYMENT	PRIOR AUTHOR. REQUIRED?
Infertility Office Visits and Associated Medical Work-Up	$5 copayment per office visit – COVERED.	Yes
Infertility Drugs, Injections, Supplies and Treatment	NOT COVERED.	Not applicable
Emergency Room Services*	COVERED with a $50 copayment; copayment waived upon hospital admission.	Yes (plan must be notified upon arrival at the emergency facility or within 48 hours)
Medical Urgent Care Center Services	$5 copayment per visit – COVERED.	Yes
Prescription Medications* (including over-the-counter medications on formulary)	$5 copayment for each prescription on formulary; COVERED.	No (if formulary) Yes (if non-formulary or if prescription requires prior authorization)
Health Education*	COVERED; Smoking Cessation – $5 copayment; Asthma Education; Hypertension Education; Diabetes Education.	No

Conditions of Participation and Benefit Coverage

In order for HealthSelect to pay for a medical, dental or pharmacy benefit, these three conditions of participation must be met by the provider and/or member:

A. The provider must be approved by HealthSelect, except in an emergency situation. In the latter case, any emergency provider can be used without prior approval or authorization from the health plan.

   Emergency care provided by a non-contracted physician, urgent care center or emergency room will be paid at HealthSelect's Standard Contract rates or at provider's billed charges, whichever is lower. If HealthSelect's Standard payment is lower than billed charges, the HealthSelect member may be billed by the provider for the difference.

B. The care and/or service must be Medically Necessary or meet the following definition of Medical Necessity:

   - Arizona Administrative Code R9-22-101 (69) defines medically necessary as ". . . those covered services provided by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law to:
   - "Prevent disease, disability and other adverse health conditions or their progression, or
   - To prolong life."

   Medical necessity is also established if:

   - The disease or condition considered for treatment is one in which the effectiveness of the proposed therapy has been demonstrated and documented,
   - The stage of disease or condition is such that therapy can affect the outcome in a positive manner and/or
   - The recipient of care has no other conditions which substantially reduce the potential for successful recovery.

C. The care, service and/or treatment must be within the accepted standards of care or practice within the health care community, be a reasonable method for treating the member's health problem(s) and not be experimental or investigational in nature. Medical research findings, government approval and/or professional standards of practice are used by HealthSelect to apply, define and justify this condition of participation.

Additional Description of Benefits*

Air Ambulance

Air Ambulance that does not originate from the scene of an accident requires prior authorization. Air ambulance from one facility to another facility also requires prior authorization.

Alternative Medicine

Benefits include only the following: Acupuncture, Homeopathy and Osteopathic Manipulation/Craniosacral Therapy, when provided by a participating provider. The only Alternative Medicine Supplies that will be covered are those described in the Definition Section. Supplies must be ordered by the contracted Alternative Medicine Provider. Members must send a copy of the doctor's order/prescription along with the paid receipt for the supply item(s) to Member Services in order to be reimbursed.

Emergency Room Services

The $50 copayment is waived if the HealthSelect member is admitted to a hospital directly from the emergency room. Admission to a hospital's observation unit does not constitute an admission to the hospital and the $50 copayment must be paid by the member.

Family Planning Services

Voluntary family planning services include physical exams, office visits and routine laboratory tests. Contraceptive devices/drugs that are covered include Norplant, IUDs, Depoprovera, diaphragms and birth control pills. Condoms and spermicidal foam are not covered as they are over-the-counter birth control items. Voluntary surgical sterilization for men and women is covered, but reversal of a sterilization technique is not covered.

Infertility services are covered for office visits, examinations, laparoscopy and hysterosalpingogram but not for subsequent treatments or medications.

HealthSelect does not cover in-vitro fertilization, artificial insemination and gamete transfer or infertility medications, injections or supplies.

Health Education Services

Health Education classes (in Smoking Cessation, Asthma Education, Diabetes Education and Hypertension only) that are presented by non-profit health agencies and institutions in Maricopa County will be covered by HealthSelect provided that the member first seeks permission from HealthSelect to attend. The member must pay the fees for the program. HealthSelect will reimburse the member for the registration fees up to $25 upon proof of payment and successful completion of the program. A Smoking Cessation class is offered by the MMC Cardiac Rehab Clinic upon PCP referral. A $5 copayment applies.

Hepatitis B Immunization

Members who work in health care facilities and perform direct patient care or work with body fluids are eligible for this immunization through their employer. All other at risk members can receive this immunization from their primary care physician and it will be paid for by HealthSelect.

Home Health Agency Skilled Services

Only those home health care services provided by a Medicare-certified Home Health Agency are eligible for coverage under HealthSelect. Attendant, home-maker and related non-health care services available through home health agencies or community-based agencies for assistance in activities of daily living in the home are not covered. Any service that is custodial in nature or designed to maintain the patient's current health and functional status in the home are not covered by HealthSelect.

Immunosuppressive Drugs

HealthSelect covers the cost of immunosuppressive drugs on formulary if it is prior authorized by HealthSelect and meets medical necessity criteria. The member is responsible for any applicable copayments.

Organ Transplants

Cornea, kidney, heart, lung, liver and bone marrow transplants will be covered by HealthSelect if the member meets all transplant candidate criteria and the procedure is not deemed experimental or investigational within the medical community and by federal and/or professional agencies, institutions or other standard-setting bodies. All conditions of participation apply to organ transplants.

HealthSelect does not cover the cost of donor searches.

HealthSelect will cover all reasonable and necessary organ bank fees. HealthSelect reserves the right to determine what is medically reasonable and necessary.

Podiatry Services

Routine foot care services are not covered by HealthSelect. The member must have a medically diagnosed health problem that, if left untreated, would result in loss of function of the lower limbs, in order for podiatry services to be covered.

Prescription Medications

HealthSelect will cover only those prescriptions which are included in Maricopa Managed Care Systems' formulary or list of approved medications that are ordered by the member's primary care physician, nurse practitioner, physician assistant or a HealthSelect-approved specialist provider.

HealthSelect uses a formulary of medications or list of approved medications. If a drug is available generically, the generic must be dispensed. The brand is listed for reference purposes only. Prescriptions are filled for a 30-day supply. A separate copayment is charged for each prescription and refill.

The copayment of $5 per prescription applies. Prescriptions must be filled at HealthSelect-approved pharmacies, except for emergencies outside of Maricopa County.

All prescriptions on formulary are covered upon hospital discharge or emergency room discharge even when written by non-contracted hospital/ER physician.

Over-the-counter drugs listed on MMCS formulary are covered.

When prescriptions are filled at a pharmacy located within a Family Health Center, they may be delivered to your home upon prior arrangement with pharmacist.

Prosthetic and Orthotic Supplies	HealthSelect sets a $7000 limit per benefit year. Requests must meet medically necessary criteria.
Weight-Loss Counseling	Members need to obtain vouchers from Member Services (602) 344-8760. Vouchers must be presented to Nutritionist at time of service (initial assessment plus three visits). Please note: Only one set of vouchers (four) will be issued for each member. Appointments can be made directly with Nutritionist at (602) 344-1015.

Exclusions and Limitations

Any services not provided or arranged by an approved contracted physician or health care provider, or approved in advance by Maricopa Managed Care Systems (MMCS) or HealthSelect (except for urgent care services outside of Maricopa County or emergency care at any location) **are not covered by HealthSelect.** The **conditions of participation** previously described in this HealthSelect Certificate booklet must be fulfilled in order for HealthSelect to cover a benefit, service or health care.

The following services are not covered by HealthSelect

A. Christian Science practitioners' services.

B. Cosmetic surgery.

C. Custodial or maintenance care.

D. Health care and delivery costs for a natural mother whose infant is being adopted by a HealthSelect subscriber are not covered. The infant is covered for the first 30 days of life and must be enrolled in HealthSelect for coverage to continue.

E. Care of a subscriber's newborn dependent is not covered after 30 days of life unless the child has been enrolled in HealthSelect. Any lapse in coverage between the 30th day of life and the effective enrollment date with HealthSelect is the subscriber's responsibility.

F. Experimental or investigational treatments including organ transplants, as defined by the Food and Drug Administration (FDA), community medical standards and other standard-setting and regulatory agencies and organizations.

G. Routine foot care by a podiatrist for adults.

H. Homemaker, attendant care, personal care and chore services not provided under Medicare Home Health Care rules and regulations.

I. Hospice services not provided through a Medicare-certified hospice.

J. Immunizations for foreign travel.

K. Factor IIX injections.

L. Full-time nursing care in the home and private-duty nursing in a health care institution. Home nursing care must meet HCFA Home Health rules and regulations.

M. Obesity treatments except when such services are an integral and necessary part of a course of treatment for an illness causing obesity.

N. Orthopedic shoes unless they are part of a leg brace and they are included in an approved orthopedist's charges.

O. Personal convenience items including, but not limited to, a telephone or television in a member's room at a hospital or skilled care facility.

P. Physical examinations, check-ups and laboratory tests that are performed to obtain insurance, a job, a pilot's license, insurance payments or to certify ability to participate in organized athletic events or for school admission.

Q. Reversal of voluntarily induced sterilization.

R. Services performed by immediate relatives or members of the member's family.

S. Routine health care services, convalescent services, home health services, rehabilitation services and any other non-emergency care or service provided outside of Maricopa County, unless prior authorized by HealthSelect.

T. Transsexual surgery and any therapy in preparation for or following such surgery.

U. Penile implants.

V. Biofeedback for conditions other than muscle re-education.

W. Breast reduction, enlargement or enhancement except for reconstructive surgery post mastectomy.

X. More than one contraceptive drug implant or more than one removal of the contraceptive drug implant in any five (5) year period, unless the procedure is determined to be medically necessary and approved by HealthSelect.

Y. Infertility treatment and medications.

Z. Treatment of sexual dysfunction.

AA. Services and treatments for learning disorders, mental retardation, developmental disabilities and behavioral problems.

BB. Circumcision, except for newborns within 30 days of birth or related to organic disease.

CC. Services or items furnished gratuitously or for which charges are not usually made.

DD. Services provided in a sanitarium for tuberculosis. This exclusion applies to court-ordered incarceration in a tuberculosis treatment facility.

EE. Medical services provided to a member, or eligible dependent, who is an inmate of, or in the custody of a public institution.

FF. Psychiatric, mental health and behavioral health care and services are not covered by HealthSelect. (Maricopa County covers this for all employees through MCC. Call 1-800-289-8167 to access Behavioral Health Services.)

GG. Physical and occupational therapy and/or speech pathology services prescribed as a maintenance regimen are not covered.

Prescription Exclusions and Limitations

A. Prescriptions must be in formulary and are only covered for a 30-day supply or 100-unit supply at a time (not to exceed 30 days). Amounts greater than this require approval from HealthSelect. Prescriptions ordered by an emergency room or urgent care center physician will only be covered for a five (5) day supply. It is expected that the patient will obtain a follow-up appointment with the Primary Care Physician and excluded from this five (5) day supply rule will be antibiotics prescribed by an emergency room or urgent care center.

B. Any prescription refilled in excess of the physician's order or refills dispensed more than one year after the original prescription date are not covered.

C. Prescriptions that are not listed in the current MMCS drug formulary will not be covered or reimbursed by HealthSelect.

D. Prescriptions that are not ordered by an approved physician or dentist will not be covered or reimbursed by HealthSelect.

E. Prescriptions that are not filled at a HealthSelect-approved pharmacy will not be covered or reimbursed by HealthSelect.

F. Experimental or investigational drugs as designated by the Food and Drug Administration and/or HCFA are not covered.

G. All physician requests for non-formulary drugs must be submitted to HealthSelect's Medical Services Department by the provider. The provider must submit reasonable evidence that the formulary drug was not effective.

H. Behavioral Health Services are not covered by HealthSelect. These services can be obtained through MCC, a separate entity contracted with Maricopa County. Call 1-800-289-8167 to request an authorization to be seen by a contracted behavioral health provider within MCC's network. HealthSelect covers behavioral health medications only when prior authorized by HealthSelect and written by an MCC-approved psychiatrist.

I. Therapeutic devices or appliances, support garments and other non-medical substances are not covered. Insulin syringes and chemotest strips are covered for insulin and non-insulin dependent diabetics only. One glucometer per lifetime is covered for diabetics.

J. Charges for administration or injection of any drug are not covered and are the responsibility of member. (Injections given by home health services are covered).

Pediatric Dental Benefits

There is always a $5 dental office visit copayment. In addition, some services have a 20% service charge. The $1200 annual limit on expenses applies to children's dental services only. The following dental services are covered for HealthSelect enrolled children:

DENTAL COVERAGE	MEMBER'S 20% SERVICE CHARGE
DIAGNOSTIC SERVICES	
Complete oral evaluation[1]	No charge
Periodic oral evaluation	No charge
Limited oral evaluation – problem-focused	No charge
X-rays – intraoral complete series including bite-wings	No charge
X-rays – intraoral – periapical – first film	No charge
X-rays – each additional film	No charge
X-rays – intraoral – occlusal film	No charge
X-rays – extraoral – first film	No charge
X-rays – extraoral – each additional film	No charge
X-rays – bitewing – single film	No charge
X-rays – bite-wings – two films	No charge
X-rays – bite-wings – four films	No charge
X-rays – panoramic film	No charge
Pulp vitality test	No charge
PREVENTIVE DENTISTRY	
Preventive education, including nutritional counseling, as part of an examination or treatment	No charge
Teeth cleaning (once every six months or as indicated by EPSDT guidelines for children)	No charge
Fluoride application	No charge
Topical application of sealant	No charge
RESTORATIVE DENTISTRY	
Amalgam restorations – primary	
One surface	$10.00
Two surfaces	$13.00
Three surfaces	$15.00
Four or more surfaces	$18.00

Pediatric Dental Benefits

DENTAL COVERAGE	MEMBER'S 20% SERVICE CHARGE
RESTORATIVE DENTISTRY (CONT.)	
Amalgam restorative – permanent	
One surface	$11.00
Two surfaces	$14.00
Three surfaces	$17.00
Four or more surfaces	$20.00
Filling	
Resin – one surface – anterior	$13.00
Resin – two surfaces – anterior	$17.00
Resin – three surfaces – anterior	$21.00
Resin – four or more surfaces involving incisal angle	$23.00
Pin retention under filling (per tooth)	$10.00
Unspecified restorative procedure (acid etch)	$10.00
Sedative filling	$9.00
Silicate cement (per restoration)	$8.00
Crown	
Stainless steel primary	$24.00
Stainless steel permanent	$29.00
Stainless steel with resin window	$32.00
ENDODONTICS	
Root canal therapy – anterior	$63.00
Root canal – bicuspid	$73.00
Root canal – molar	$103.00
Pulp cap – direct or indirect	No charge
PERIODONTICS	
Gingival curettage (per quadrant)	$34.00
Gingivoplasty (per quadrant)	$68.00
Gingival flap (per quadrant)	$51.00
Osseous surgery (per quadrant)	$140.00
Gingivectomy (per tooth – fewer than six teeth)	$21.00
Scaling and root planing (per quadrant)	$23.00

Pediatric Dental Benefits

DENTAL COVERAGE	MEMBER'S 20% SERVICE CHARGE
REPAIRS	
Re-cement inlay, crown or bridge	$9.00
ORAL SURGERY	
Routine extraction	
One tooth	$13.00
Each additional tooth	$12.00
Surgical extraction of erupted tooth	$24.00
Removal of impacted tooth	
Soft tissue	$28.00
Partially bony impaction	$36.00
Completely bony	$44.00
Surgical removal of residual root	$28.00
Biopsy of oral tissue – hard	$28.00
Biopsy of oral tissue – soft	$36.00
OTHER SERVICES	
Analgesia	$7.00
Palliative emergency treatment of dental pain – mixed procedure	No charge

HealthSelect covers pediatric dental services for children from birth through age 18 years. Pediatric Dental coverage ends on the 19th birthday, even if the subscriber enrolls the child as a full-time student. HealthSelect members may seek dental care without referral by the primary care physician. The dental provider will obtain necessary authorizations for treatment of the child as needed.

Coverage of tooth replacements may be available to some children. The tooth being replaced must have been a permanent one. Coverage is determined on a case-by-case basis by HealthSelect.

Pediatric Dental Exclusions and Limitations

HealthSelect does not provide coverage for prosthetics or prosthetic repairs. Emergency treatment secondary to traumatic injury to the teeth, gums and/or bone is available within the hospital or outpatient setting. Member may be responsible for payment of follow-up treatments not covered in the above benefit list or for expenses that exceed the $1200 annual limit on expenses for children's dental services.

Dental services for children must meet the Conditions of Participation described previously in this HealthSelect Certificate. See other Exclusions and Limitations (Pediatric and Adult Dental Services) Section.

There is always a $5.00 dental office visit copayment. In addition, some services require a 20% service charge. There is a $1200 annual limit.

Adult Dental Benefits

There is always a $5 dental office copayment. In addition, some services require a 20% service charge. There is no annual limit. The following dental services are covered for HealthSelect enrolled adults:

DENTAL COVERAGE	MEMBER'S 20% SERVICE CHARGE
DIAGNOSTIC SERVICES	
Comprehensive oral exam[1]	No charge
Periodic oral exam (once per contract year)	No charge
Limited oral evaluation – problem-focused	No charge
X-rays – full mouth	No charge
X-rays – intraoral perapical – first film	No charge
X-rays – intraoral perapical – each additional film	No charge
X-rays – intraoral – occlusal film	No charge
X-rays – extraoral	No charge
X-rays – extraoral – each additional film	No charge
X-rays – bite-wings single film	No charge
X-rays – bite-wings – two films	No charge
X-rays – bite-wings – four films	No charge
X-rays – bite-wings – additional	No charge
X-rays – panoramic film	No charge
Pulp vitality tests	No charge
Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment**)	No charge
PREVENTIVE DENTISTRY	
Dental prophylaxis[2] – adult	No charge
Fluoride application – adult	No charge
Oral hygiene instruction	No charge
Topical application of sealant	No charge
RESTORATIVE DENTISTRY (limitation of four fillings per year) Member responsible for cost beyond four fillings per year	
Amalgam – permanent	
One surface	$11.00
Two surfaces	$14.00
Three surfaces	$17.00
Four or more surfaces	$20.00
Silicate cement (per restoration)	$8.00

Adult Dental Benefits

DENTAL COVERAGE	MEMBER'S 20% SERVICE CHARGE
RESTORATIVE DENTISTRY (CONT.)	
Filling	
Resin – one surface – anterior	$13.00
Resin – two surfaces – anterior	$17.00
Resin – three surfaces – anterior	$21.00
Resin – four or more surfaces – involving incisal angle	$23.00
Re-cement inlay	$8.00
Re-cement crown	$9.00
Sedative filling	$9.00
Core build-up, including any pins	$21.00
Pin retention per tooth, in addition to restoration	$10.00
Unspecified restorative procedure (acid etch)	$10.00
ORAL SURGERY	
Routine extraction of one tooth	$13.00
Routine extraction of each additional tooth	$12.00
OTHER DENTAL SERVICES	
Stainless steel crowns (Limitation of two per contract year)	$29.00
Prefabricated stainless steel crown – permanent	$32.00
Prefabricated stainless steel crown with resin window	No charge
Emergency palliative treatment	$50.00 per visit
Emergency care (out of area, see HealthSelect Dental Limitations)	
Analgesia	$7.00
Office visit	$5.00

***Note* – The HealthSelect Dental Benefit Plan Does Not Cover:**

- Bridges or bridge repair
- Crowns (except stainless steel crowns)
- Crown repair
- Orthodontics
- Endodontics
- Periodontics
- Prosthodontics

**Need authorization from HealthSelect.

[1]Once per contract year.

[2]Routine cleaning once each coverage year.

HealthSelect dentists may make referrals to other dental specialties for excluded services above. However, these services are not covered by HealthSelect and will become member's financial responsibility.

Adult Dental Exclusions and Limitations

HealthSelect does not provide coverage for prosthetics or prosthetic repairs. Emergency treatment secondary to traumatic injury to the teeth, gums and/or bone is available within the hospital or outpatient setting. Member may be responsible for payment of follow-up treatments that are not covered services under HealthSelect.

Other Exclusions and Limitations
(Pediatric and Adult Dental Services)

A. Any dental service not addressed in the previous list of Covered Benefits.

B. Gold and precious metals are not covered for tooth restorations/replacements.

C. Bridges, dentures and tooth implants are not covered.

D. Out-of-area and out-of-plan dental coverage is limited to emergencies only and is limited to a maximum coverage amount of $50.00 per visit. The member is responsible for all charges in excess of $50.00.

E. Surgical grafting procedures are not covered.

F. Treatment of tooth problems related to congenital or developmental malformations are not covered. This includes, but is not limited to, cleft palate, enamel hypoplasia, fluorosis (brown or white stains on the teeth), maxillary and/or mandibular malformations and anodontia.

G. General anesthetic is not a covered benefit for pediatric dental services. It would be covered in an emergent care setting (hospital emergency room) or in an inpatient setting for treatment of an emergent, traumatic injury to the teeth, gums and bone.

H. Cosmetic treatments and services are not covered.

I. Full-mouth rehabilitation, periodontal splints, restoration of tooth structure lost from attrition and restoration for malalignment of the teeth are not covered.

J. Any single procedure or procedures started prior to the date the member became eligible for such services under HealthSelect. Dental treatment in progress at the time of member disenrollment or ineligibility for coverage is not covered by HealthSelect after the disenrollment or ineligibility date.

K. Treatment and/or removal of oral tumors would be covered as a medical benefit, not a dental benefit.

L. Orthodontic care and supplies, including x-rays for orthodontic treatment and extractions are not covered.

M. Prosthetics repair and oral surgery (except for routine extraction).

N. No endodontics for adults.

O. No periodontics for adults.

P. No orthodontics for adults and children.

Q. No prosthodontics for adults.

R. Prophylaxis will be provided only once every contract year for adults. Additional prophylaxis requires prior authorization from HealthSelect.

S. Full-mouth x-rays will be provided no more than once every contract year.

T. Any single procedure or procedures (including root canals) started prior to the date the member became eligible for such services under this agreement will not be covered.